Characteristics of suicidal adolescents and young adults presenting to primary care with non-suicidal (indeed non-psychological) complaints

THOMAS E. JOINER, JR., JON J. PFAFF, JOHN G. ACRES *

Background: Some young people presenting to primary care experience suicidal symptoms that they do not report. Method: We conducted a survey of suicidal ideation among 15–24-year-old patients presenting to Australian general practitioners. Results: Patients who experienced substantial, but unstated, suicidal symptoms tended to be female and somewhat younger; their depression and distress levels, while not as high as suicidal patients with psychological complaints, were nonetheless elevated. Conclusions: Young patients who evince any signs of depression or distress, particularly but not only young females, should be evaluated regarding psychological symptoms, including suicidal ideation.

Keywords: non-suicidal complaints, primary care, suicidal ideation

A proportion of general practitioners’ young patients harbour suicidal ideation that they do not report. Suicidal symptoms in young people are relatively common (especially in mid-adolescence), and it would be unusual if this prevalence rate did not apply to patients in doctors’ offices. Adolescents and young adults may not be forthcoming with health care providers, especially regarding such things as suicidal ideas, which can carry a stigma in some settings, including, unfortunately, health settings. Moreover, in a previous study, it was reported that 21.4% of young patients complaining of medical, non-psychological symptoms scored above a clinical cut-point on a suicide screening measure.

The training of generalists in the identification and treatment of patients at risk of suicide has been advocated, based on the suggestion that they often may be consulted by persons who later go on to attempt or commit suicide. Although this view has been criticized, two recent studies suggest that younger patients’ visits to their primary care providers increase in the weeks either before their deaths or before hospital admission for suicidal behaviour, and there is evidence that training primary care providers can lead to a fall in local suicide rates, at least on a short-term basis.

Of course, those who do not forthrightly report suicidal ideation are the hardest to recognize. Accordingly, we sought to elucidate such patients’ characteristics (age, gender, depressive symptoms, general distress symptoms), among 15–24-year-old patients attending the clinics of Australian general practitioners. Specifically, we compared young people who endorsed suicidal ideation on a screening measure and who presented with a psychological problem, to young people who also endorsed suicidal ideation, but who, despite suicidal symptoms, presented with a physical problem.

METHOD

Study population
Participants were consecutive patients, aged 15–24 years, attending the clinics of 247 general practitioners in the Australian States of Tasmania, Victoria, and Western Australia. A maximum of twenty patients from each clinic was invited to participate. The ethics committee of Princess Margaret Hospital in Perth, Western Australia, approved the study.

The initial sample consisted of 2,851 15–24-year-old patients presenting to general practitioner clinics, who had complete data on a suicide screening measure. Ninety one per cent (91%) of 15–24-year-old patients presenting during the period of the study agreed to participate. Participants were predominantly female (66%) and had a mean age of 19.6 years. Most patients were born in Australia (90.1%). English was the most common language spoken in patients’ homes, with other European languages and Asian languages accounting for only 3.7% and 1.5%, respectively.
As described later, approximately 9% of these patients met or exceeded a relatively high threshold on a measure of suicidal symptoms, and the focus of this report is on these patients.

Survey methods
Each participating clinic offered patients awaiting consultations an envelope containing study materials, including an informed consent document, self-report instruments, and a return envelope. Participants’ instructions were to read and, if they agreed to participate, to sign the informed consent document, complete the self-report questionnaires, seal all documents in the envelope, and return them to the nurse or receptionist. Study materials were then sent directly to the study’s authors by clinic staff. General practitioners were not aware of which patients had elected to participate in the study and were not able to review patients’ self-report questionnaires (although it should be acknowledged that physicians’ awareness of the study in general might have affected their assessments of patients, probably by making them more sensitive to psychological complaints). Each general practitioner completed a summary sheet on 15–24-year-old patients attending his or her clinic during the study period. Among other things, the sheet asked for the patient’s primary presenting complaint, which was coded for the purposes of this paper as either a psychological or a physical complaint (overall, 85% presented with a psychological complaint, and 15%, with a psychological complaint; because participants were recruited in an essentially random fashion from many different primary care clinics, we assume that the types of presenting complaints were roughly representative of those seen in the average primary care clinic). Study authors were thus able to directly match presenting complaint to patients’ self-report measures, which are described next.

Instruments
Study instruments, all with documented reliability and validity, included the General Health Questionnaire–12 (GHQ–12),12 a 12-item self-report questionnaire designed to assess general emotional distress, scores on which range from 0 to 12 (2,835 of 2,851 had complete data on this measure); the Center for Epidemiological Studies Depression Scale (CES–D),13 a 20-item self-report questionnaire developed for use in epidemiological surveys to identify persons with depression, scores on which range from 0 to 60 (2,733 of 2,851 had complete data on this measure); and the Depressive Symptom Inventory – Suicidality Subscale (DSI–SS),14 a four-item self-report questionnaire designed to identify the frequency and intensity of suicidal ideation in the past two weeks, on which item scores range from 0 to 3, and inventory scores, from 0 to 12, with higher scores reflecting greater severity of suicidal ideation (all participants had complete data on this measure). DSI–SS items assess frequency of suicidal ideation, development of a suicide plan, an inability to control suicidal thoughts, and suicidal impulses in most situations. For purposes of this study, a relatively high threshold for suicidality was used (a DSI–SS inventory score of 4 or higher; less than 9% of the sample, or approximately 270 patients, met this criterion), so that a clear group of patients with suicidal ideation would be identified. Of these patients, 32% presented with a psychological complaint; 68%, with a non-psychological complaint.

RESULTS
We sought characteristics that distinguished suicidal young people presenting with a psychological problem from suicidal young people who, despite suicidal symptoms, present with a physical problem. We thus compared these two groups on gender distribution, age, depressive symptoms (CES–D), and general emotional distress (GHQ–12). Suicidal patients with physical presentations tended to be female (chi square [df=1] = 8.88, p<0.01; 74% of such patients were female; expected value was 67%), younger (F [1,268] = 4.85, p<0.05; means were 19.2 years versus 20.03 years), and reported fewer depressive symptoms on the CES–D (F [1,246; df lower due to missing data] = 26.66, p<0.01; means were 31.32 versus 39.00), and less general distress on the GHQ–12 (F [1,264; df lower due to missing data] = 6.51, p<0.05; means were 6.89 versus 8.23). In each of these analyses, the covariance of DSI–SS scores did not change the direction, magnitude, or significance of findings (it was therefore not the case that between-group differences in gender distribution, age, CES–D, and GHQ were explained by between-group differences in suicidal symptom level). It is important to note that both groups, including the suicidal patients with physical presentations, scored above usual clinical cut-offs on the CES–D depression measure and the GHQ distress measure.

DISCUSSION
In the present study, which set a relatively clear threshold for suicidal ideation, approximately 9% of all 15–24-year-old patients met or exceeded the threshold. About 1 in 10 general practice patients, then, experienced suicidal symptoms — an issue that obviously warrants general concern. The issue is further complicated, however, by the fact that over 60% of suicidal young patients presented to general practitioners with a physical (not psychological) complaint. Overall, about 1 in 20 young patients in general settings may experience substantial, but unstated, suicidal symptoms. These patients tend to be female and somewhat younger (but suicidality in males should not be discounted, because among other reasons, males are more likely than females to complete suicide15); their depression and distress levels, while not as high as suicidal patients with psychological complaints, were nonetheless elevated. Young patients who evince any signs of depression or distress should be asked about psychological symptoms, including suicidal ideation. Robinson and Roter found that psychologically distressed patients presenting with somatic complaints will disclose their distress if their doctors inquire about it.
Primary care providers might consider a screening instrument, such as the GHQ–12 and/or CES–D, and a brief suicidal ideation questionnaire such as the DSI–SS, for patients presenting to their practices, especially if resources are available for interpreting positive screen scores and appropriate and acceptable interventions and referrals are available. The study has limitations that should be considered when interpreting these findings. No measure of test-taking approach was included, and thus we have no means to address whether high-scorers on the DSI–SS may be exaggerating suicidal symptoms that actually are minimal. The measure is meant as an initial screen, and so in the case of high-scorers and symptom exaggeration, more in-depth testing and interviewing can assess for the possibility of exaggeration. The study is also limited, of course, to young people presenting to Australian general practitioners. In conclusion, primary care providers should be aware that a proportion of young patients harbour suicidal ideation that they do not report. Such patients tend to be younger and female, and are depressed and distressed (although less so than suicidal patients who report a psychological problem). Young patients who evince any signs of depression or distress, particularly but not only young females, should be asked about psychological symptoms, including suicidal ideation.

This work was conducted under the auspices of the Psychiatry Department, Princess Margaret Hospital for Children, Perth, Australia. Funding for this project was provided by a grant from the Commonwealth Department of Health and Aged Care, Mental Health Branch, Australia.

REFERENCES


Received 12 June 2001, accepted 18 October 2001